

PREFERRED DRUG LIST

When a generic product is available, for a preferred or non-preferred agent, the pharmacy will receive a lower reimbursement rate for the branded product unless a DAW PA is obtained.

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INHALATION AGENTS

Anticholinergics for the Maintenance Treatment of COPD

Preferred	Non-Preferred, Prior Authorization Required
Spiriva® Handihaler (tiotropium)	Atrovent HFA® (ipratropium bromide) Incruse Ellipta® (umeclidinium bromide) Spiriva® Respimat (tiotropium) Tudorza PressAir® (aclidinium)

Beta₂-Agonists - Long-Acting

*Clinical prior authorization may apply

Preferred	Non-Preferred, Prior Authorization Required
Serevent Diskus® (salmeterol)	Arcapta® (indacaterol) Brovana® (arformoterol) Perforomist® (formoterol) Striverdi Respimat® (olodaterol)

Beta₂-Agonists - Short-Acting

Preferred	Non-Preferred, Prior Authorization Required
AccuNeb® (albuterol)	Maxair® (pirbuterol)
ProAir HFA® (albuterol)	ProAir RespiClick® (albuterol)
Proventil HFA® (albuterol)	Ventolin HFA® (albuterol)
Proventil® Inhalation Solution (albuterol)	Xopenex® Inhalation Solution (levalbuterol)
Ventolin® Inhalation Solution (albuterol)	Xopenex HFA® (levalbuterol)

Beta₂-Agonists - Long-Acting/Anticholinergics

*Clinical prior authorization may apply

Preferred	Non-Preferred, Prior Authorization Required
Anoro Ellipta® (umeclidinium/vilanterol)	Utibron Neohaler® (indacaterol/glycopyrrrolate)
Bevespi Aerosphere® (glycopyrrrolate/formoterol)	
Stiolto Respimat® (tiotropium/olodaterol)	

Beta₂-Agonists - Long-Acting/Corticosteroids

*Clinical prior authorization may apply

Preferred	Non-Preferred, Prior Authorization Required
Advair® Diskus (fluticasone/salmeterol)	Advair® HFA (fluticasone/salmeterol)
Dulera® (formoterol/mometasone)	Breo Ellipta® (fluticasone/vilanterol)
Symbicort® (budesonide/formoterol)	



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INHALATION AGENTS (continued)

Corticosteroids	
Preferred	Non-Preferred, Prior Authorization Required
Asmanex® (mometasone)	Aerospan® (flunisolide)
Flovent® HFA (fluticasone)	Alvesco® (ciclesonide)
Pulmicort Flexhaler® (budesonide)	Arnuity Ellipta® (fluticasone)
Pulmicort Respules® (budesonide) *≤ 6 years of age only	Asmanex HFA® (mometasone)
QVAR® (beclomethasone)	Flovent® Diskus (fluticasone)
	Pulmicort Respules® (budesonide) *> 7 years of age

Tobramycin Products

Preferred	Non-Preferred, Prior Authorization Required
Bethkis® (tobramycin)	Kitabis pak® (tobramycin nebulizer)
Tobi® (tobramycin)	Tobi Podhaler® (tobramycin)

INTRANASAL AGENTS

Antihistamines	
Preferred	Non-Preferred, Prior Authorization Required
Astelin® (azelastine)	Astepro® (azelastine) Patanase® (olopatadine)

Corticosteroids

Preferred	Non-Preferred, Prior Authorization Required
Flonase® (fluticasone)	Beconase AQ® (beclomethasone)
Qnasl® (beclomethasone)	Nasacort AQ®(triamcinolone) Nasarel® (flunisolide) Nasonex® (mometasone) Omnaris® (ciclesonide) Rhinocort AQ® (budesonide) Veramyst® (fluticasone) Zetonna® (ciclesonide)

OPHTHALMIC AGENTS

Antihistamine/Mast Cell Stabilizers	
Preferred	Non-Preferred, Prior Authorization Required
Alaway® (ketotifen)	Alocril® (nedocromil)
Cromolyn® (cromolyn)	Alomide® (Iodoxamide)
Patanol® (olopatadine)	Bepreve® (bepotastine)
Pazeo® (olopatadine)	Elestat® (epinastine)
Refresh® (ketotifen)	Emadine® (emedastine)
Zaditor® (ketotifen)	Lastacift® (alcaftadine) Optivar® (azelastine) Pataday® (olopatadine)

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OPHTHALMIC AGENTS (continued)

Anti-Infective/Steroid Combinations

Preferred	Non-Preferred, Prior Authorization Required
Blephamide® (sulfacetamide/prednisolone)	Blephamide S.O.P.® (sulfacetamide/prednisolone)
Maxitrol® (neomycin/polymyxin/dexamethasone)	TobraDex® (tobramycin/dexamethasone)
Pred-G® (prednisolone/gentamicin)	TobraDex ST® (tobramycin/dexamethasone)
Pred-G S.O.P.® (prednisolone/Gentamicin)	

Carbonic Anhydrase Inhibitors

Preferred	Non-Preferred, Prior Authorization Required
Azopt® (brinzolamide)	Trusopt® (dorzolamide)
Simbrinza® (brinzolamide/brimonidine tartrate)	

Non-Steroidal Anti-Inflammatory Drugs - Ophthalmic

Preferred	Non-Preferred, Prior Authorization Required
Acular® (ketorolac)	Acular LS® (ketorolac)
Ilevro® (nepafenac)	Acuvail® (ketorolac)
Nevanac® (nepafenac)	Bromday® (bromfenac)
Ocufen® (flurbiprofen)	BromSite® (bromfenac)
Voltaren® Ophthalmic (diclofenac)	Prolensa® (bromfenac)

Prostaglandin Analogs

Preferred	Non-Preferred, Prior Authorization Required
Xalatan® (latanoprost)	Lumigan® (bimatoprost) Travatan Z® (travoprost) Zioptan® (tafluprost)

OTIC AGENTS

Anti-Infective/Steroid Combinations

Preferred	Non-Preferred, Prior Authorization Required
Cipro HC® (ciprofloxacin/hydrocortisone)	Acetasol HC® (acetic acid/hydrocortisone)
Ciprodex® (ciprofloxacin/dexameth)	Cortisporin® Otic Suspension (neomycin/polymyxin B/hc)
Cortisporin® Otic Solution (neomycin/polymyxin B/hc)	Cortisporin-TC® (neomy/colist/hc/thonz) Otovel® (ciprofloxacin/fluocinolone)

ORAL/INJECTABLE/TOPICAL AGENTS

ACE Inhibitors

Preferred	Non-Preferred, Prior Authorization Required
Accupril® (quinapril)	Aceon® (perindopril)
Altace® (ramipril)	Capoten® (captopril)
Lotensin® (benazepril)	Epaned® (enalapril solution)
Monopril® (fosinopril)	Mavik®(trandolapril)
Prinivil® (lisinopril)	Univasc® (moexipril)
Zestril® (lisinopril)	Vasotec® (enalapril)



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ORAL/INJECTABLE/TOPICAL AGENTS (continued)

ACE Inhibitor/Calcium Channel Blocker Combinations

Preferred	Non-Preferred, Prior Authorization Required
Lotrel® (benazepril/amlodipine)	Tarka® (trandolapril/verapamil)

Acne Agents - Topical

*Clinical prior authorization may apply

Preferred	Non-Preferred, Prior Authorization Required
Acanya® (benzoyl peroxide-clindamycin) gel	Avar® (sulfacetamide-sulfur) pads
Aczone® (dapsone) gel	Avar-E® Emollient (sulfacetamide-sulfur) cream
Atralin® (tretinoin) gel	Avar-E Green® (sulfacetamide-sulfur) cream
Avita® (tretinoin) cream	Avar LS® (sulfacetamide-sulfur) pads
Azelex® (azelaic acid) cream	Benzaclin® (benzoyl peroxide-clindamycin) gel
Cerisa® (sulfacetamide-sulfur) emulsion	Benzamycin® (benzoyl peroxide-erythromycin) gel
Cleocin-T® (clindamycin) lotion	Clindacin ETZ® (clindamycin) swab
Cleocin-T® (clindamycin) solution	Differin® (adapalene) cream
Clindacin-P® (clindamycin) swab	Differin® (adapalene) gel
Clindagel® (clindamycin) gel	Duac® (benzoyl peroxide-clindamycin) gel
Epiduo® (benzoyl peroxide-adapalene) gel	Epiduo Forte® (adapalene/benzoyl peroxide)
Ery® (erythromycin) pads	Erygel® (erythromycin) gel
Erythromycin solution	Evoclin® (clindamycin phosphate) foam
Onexton® (benzoyl peroxide-clindamycin) gel	Fabior® (tazarotene) foam
Retin-A® (tretinoin) cream	Klaron® (sulfacetamide) lotion
SSS 10-5® (sulfacetamide-sulfur) cream	Neuac® (clindamycin/benzoyl peroxide)
Sulfacetamide suspension	Retin-A® Micro (tretinoin) gel
Sulfacetamide-Sulfur lotion	Rosanil® Cleanser (sulfacetamide-sulfur) emulsion
Tazorac® (tazarotene) cream	Rosula® (sulfacetamide-sulfur) pads
Tazorac® (tazarotene) gel	Sumadan® (sulfacetamide-sulfur) kit
Zencia® (sulfacetamide-sulfur) liquid	Sumadan® Wash (sulfacetamide-sulfur) liquid
Ziana® (clindamycin-tretinoin)	Sumaxin® (sulfacetamide-sulfur) pads
	Sumaxin TS® (sulfacetamide-sulfur) suspension
	Sumaxin® Wash (sulfacetamide-sulfur) liquid
	Veltin® (clindamycin-tretinoin)

ADHD – Amphetamine Type

Preferred	Non-Preferred, Prior Authorization Required
Adderall® (dextroamphetamine/amphetamine)	Adzenys XR-ODT® (amphetamine ER)
Adderall XR® (dextroamphetamine/amphetamine ER)	Desoxyn® (methamphetamine)
Dexedrine® tablets (dextroamphetamine)	Dyanavel XR® (amphetamine ER)
Dexedrine ER® capsules (dextroamphetamine ER)	Procentra® (dextroamphetamine)
Dextrostat® (dextroamphetamine)	Zenzedi® (dextroamphetamine)
Vyvanse® (lisdexamfetamine)	



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ORAL/INJECTABLE/TOPICAL AGENTS (continued)

ADHD – Methylphenidate Type

Preferred	Non-Preferred, Prior Authorization Required
Concerta® (methylphenidate ER)	Aptensio XR® (methylphenidate ER)
Daytrana® (methylphenidate)	Methylin Chewable® (methylphenidate)
Focalin® (dexmethylphenidate)	Methylin Solution® (methylphenidate)
Focalin XR® (dexmethylphenidate ER)	Metadate ER® (methylphenidate ER)
Metadate CD® (methylphenidate 30/70)	Ritalin LA® (methylphenidate 50/50)
Quillichew ER® (methylphenidate ER)	Ritalin SR® (methylphenidate ER)
Quillivant XR® (methylphenidate ER)	
Ritalin® (methylphenidate)	

Adjunct Anti-epileptics

**Clinical prior authorization may apply*

Preferred	Non-Preferred, Prior Authorization Required
Keppra® (levetiracetam)	Banzel® (rufinamide)
Keppra® XR (levetiracetam XR)	Briviact® (brivaracetam)
Lyrica® (pregabalin)	Fycompa® (perampanel)
Neurontin® (gabapentin)	Gabitrii® (tiagabine)
Zonegran® (zonisamide)	Onfi® (clobazam)
	Oxtellar XR® (oxcarbazepine)
	Potiga® (ezogabine)
	Spritam® (levetiracetam)

Alpha glucosidase Inhibitors

Preferred	Non-Preferred, Prior Authorization Required
Precose® (acarbose)	Glyset® (miglitol)

Anaphylaxis Agents

Preferred	Non-Preferred, Prior Authorization Required
Epipen® (epinephrine auto inject)	Adrenaclick® (epinephrine auto inject)
Epipen Jr® (epinephrine auto inject)	Epinephrine auto injectors

Anticoagulants

Preferred	Non-Preferred, Prior Authorization Required
Coumadin® (warfarin)	Savaysa® (edoxaban)
Eliquis® (apixaban)	
Pradaxa® (dabigatran)	
Xarelto® (rivaroxaban)	

Antidepressants - SNRIs

Preferred	Non-Preferred, Prior Authorization Required
Cymbalta® (duloxetine)	Effexor XR® tablets (venlafaxine ER)
Effexor® (venlafaxine)	Fetzima® (levomilnacipran)
Effexor XR® capsules (venlafaxine ER)	Savella® (milnacipran)
Pristiq® (desvenlafaxine)	



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Antidepressants - SSRIs	
Preferred	Non-Preferred, Prior Authorization Required
Celexa® (citalopram) Lexapro® (escitalopram) Luvox® (fluvoxamine) Paxil® (paroxetine) Prozac® capsules (fluoxetine) Prozac® solution (fluoxetine) Zoloft® (sertraline)	Celexa® solution (citalopram) Lexapro® solution (escitalopram) Paxil CR® (paroxetine ER) Paxil® solution (paroxetine) Pexeva® (paroxetine) Prozac® tablets (fluoxetine) Zoloft® solution (sertraline)
Antidepressants - Tricyclics	
Preferred	Non-Preferred, Prior Authorization Required
Doxepin capsules and solution Elavil® (amitriptyline) Pamelor® (nortriptyline) Tofranil® (imipramine)	Amoxapine Anafranil® (clomipramine) Norpramin® (desipramine) Pamelor® solution (nortriptyline) Surmontil® (trimipramine) Tofranil - PM® (imipramine) Vivactil® (protriptyline)
Anti-emetics Cannabinoid <i>*Clinical prior authorization may apply</i>	
Preferred	Non-Preferred, Prior Authorization Required
Marinol® (dronabinol)	Cesamet® (nabilone)
Anti-emetics Serotonin 5HT ₃ Antagonists	
Preferred	Non-Preferred, Prior Authorization Required
Zofran® (ondansetron) Zofran ODT® (ondansetron)	Anzemet® (dolasetron) Gransol® (granisetron) Kytril® (granisetron) Sancuso® (granisetron) Zuplenz® (ondansetron)
Anti-Histamines - Non-Sedating	
Preferred	Non-Preferred, Prior Authorization Required
Claritin® (loratadine) Claritin 24-hr Allergy® (loratadine) Claritin® Syrup (loratadine) Zyrtec® (cetirizine) Zyrtec® Syrup (cetirizine)	Allegra® (fexofenadine) Allegra® ODT (fexofenadine) Clarinex® (desloratadine) Claritin Hives Relief® (loratadine) Claritin RediTabs® (loratadine) Xyzal® (levocetirizine)
The following drugs are covered for KBH only: Allegra-D® (fexofenadine/pseudoephedrine) Allegra-D24® (fexofenadine/pseudoephedrine) Clarinex-D 12-hour® (desloratadine/pseudoephedrine) Clarinex-D 24-hour® (desloratadine/pseudoephedrine)	



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ORAL/INJECTABLE/TOPICAL AGENTS (continued)

Anti-Viral - Herpes

Preferred	Non-Preferred, Prior Authorization Required
Valtrex® (valacyclovir)	Famvir® (famciclovir)
Zovirax® (acyclovir) (oral dosage forms only)	Sitavig® (acyclovir)

ARBs

Preferred	Non-Preferred, Prior Authorization Required
Avalide® (irbesartan/HCTZ)	Atacand® (candesartan)
Avapro® (irbesartan)	Atacand HCT® (candesartan/HCTZ)
Cozaar® (losartan)	Benicar® (olmesartan)
Diovan® (valsartan)	Benicar HCT® (olmesartan/HCTZ)
Diovan HCT® (valsartan/HCTZ)	Edarbyclor® (azilsartan medoxomil)
Edarbyclor® (azilsartan medoxomil/chlorthalidone)	Micardis® (telmisartan)
Entresto® (sacubitril/valsartan)	Micardis HCT® (telmisartan/HCTZ)
Hyzaar® (losartan/HCTZ)	Teveten® (eprosartan)
Tribenzor® (olmesartan/amlodipine/HCTZ)	

ARB/Calcium Channel Blocker Combinations

Preferred	Non-Preferred, Prior Authorization Required
Azor® (amlodipine/olmesartan)	Twynsta® (amlodipine/telmisartan)
Exforge® (amlodipine/valsartan)	

Beta-Blockers

Preferred	Non-Preferred, Prior Authorization Required
Betapace® (sotalol)	Blocadren® (timolol)
Betapace AF® (sotalol AF)	Bystolic® (nebivolol)
Coreg® (carvedilol)	Coreg CR® (carvedilol CR)
Inderal® (propranolol)	Corgard® (nadolol)
Lopressor® (metoprolol tartrate)	Corzide® (nadolol/bendroflumethiazide)
Sectral® (acebutolol)	Dutoprol® (metoprolol/HCTZ)
Tenormin® (atenolol)	Inderal® LA (propranolol XL)
Ziac® (bisoprolol/HCTZ)	InnoPran® XL (propranolol XL)
	Kerlone® (betaxolol)
	Labetalol (labetalol)
	Levatol® (penbutolol)
	Lopressor HCT® (metoprolol/HCTZ)
	Toprol® XL (metoprolol succinate)
	Visken® (pindolol)
	Zebeta® (bisoprolol)



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ORAL/INJECTABLE/TOPICAL AGENTS (continued)

Biguanides

Preferred	Non-Preferred, Prior Authorization Required
Glucophage® (metformin)	Fortamet® (metformin ER)
Glucophage® XR (metformin ER)	Glumetza® (metformin ER) Riomet® (metformin oral solution)

Bile Acid Sequestrants

Preferred	Non-Preferred, Prior Authorization Required
Colestid® Tablets (colestipol)	Colestid® Granules (colestipol)
Prevalite® Powder (cholestyramine light)	Questran® (cholestyramine)
Prevalite® Powder Packs (cholestyramine light)	Questran Light® (cholestyramine light)
Welchol® Powder (colesevelam)	
Welchol® Tablets (colesevelam)	

Bisphosphonates

Preferred	Non-Preferred, Prior Authorization Required
Fosamax® (alendronate)	Actonel® (risedronate) Atelvia® (risedronate) Binosto® (alendronate) Boniva® (ibandronate) Fosamax Plus D® (alendronate/cholecalciferol)

Bladder Relaxant Agents

Preferred	Non-Preferred, Prior Authorization Required
Ditropan® (oxybutynin)	Detrol® (tolterodine)
Ditropan XL® (oxybutynin ER)	Detrol® LA (tolterodine ER)
Enablex® (darifenacin)	Gelnique® Gel (oxybutynin)
Myrbetriq®(mirabegron)	Oxytrol® Patch (oxybutynin)
Toviaz® (fesoterodine)	Sanctura® (trospium)
Vesicare® (solifenacina)	Sanctura XR® (trospium ER)
	Urispas® (flavoxate)

Calcium Channel Blockers - Dihydropyridines

Preferred	Non-Preferred, Prior Authorization Required
Norvasc® (amlodipine)	Adalat® (nifedipine IR)
Plendil® (felodipine)	Adalat CC® (nifedipine ER)
Procardia® XL (nifedipine ER)	Cardene® (nicardipine IR) Cardene® SR (nicardipine SR) DynaCirc® (isradipine IR) Sular® (nisoldipine)

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ORAL/INJECTABLE/TOPICAL AGENTS (continued)

Calcium Channel Blockers - Non-Dihydropyridines	
Preferred	Non-Preferred, Prior Authorization Required
Calan® (verapamil IR)	Cardizem LA® (diltiazem)
Calan SR® (verapamil SR)	Cardizem SR® (diltiazem)
Cardizem® (diltiazem IR)	Matzim LA® (diltiazem ER)
Cardizem CD® (diltiazem)	Tiazac® (diltiazem)
Cartia XT® (diltiazem ER)	Verelan® (verapamil SR)
Dilt- XR® (diltiazem ER)	Verelan PM® (verapamil)
Isoptin SR® (verapamil SR)	
Taztia XT ®(diltiazem ER)	

Constipation Agents – Opioid Induced Cause	
*Clinical prior authorization may apply	
Preferred	Non-Preferred, Prior Authorization Required
Movantik® (naloxegol)	Relistor® (methylnaltrexone)

COX-II Inhibitors	
Preferred	Non-Preferred
Celebrex® (celecoxib)	

DPP-4 Inhibitors	
Preferred	Non-Preferred, Prior Authorization Required
Glyxambi® (empagliflozin/linagliptin)	Janumet XR® (sitagliptin/metformin XR)
Janumet® (sotaliptin/metformin)	Jentadueto® (linagliptin/metformin)
Januvia® (sitagliptin)	Jentadueto XR® (linagliptin/metformin XR)
Kombiglyze XR® (saxagliptin/metformin)	Kazano® (alogliptin/metformin)
Onglyza® (saxagliptin)	Nesina® (alogliptin)
	Oseni® (alogliptin/pioglitazone)
	Tradjenta® (linagliptin)

Erythropoiesis-Stimulating Agents	
Preferred	Non-Preferred, Prior Authorization Required
Epogen® (epoetin alfa)	Aranesp® (darbepoetin alfa) Procrit® (epoetin alfa)

Fibrin Acid Derivatives	
Preferred	Non-Preferred, Prior Authorization Required
Fenofibrate generics Lopid® (gemfibrozil)	Antara® (fenofibrate) Fenoglide® (fenofibrate) Lipofen® (fenofibrate) Lofibra® (fenofibrate) Tricor® (fenofibrate) Triglide® (fenofibrate) Trilipix® (fenofibric acid)

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ORAL/INJECTABLE/TOPICAL AGENTS (continued)

GLP- 1 RA (formerly Incretin Mimetics)

**Clinical prior authorization may apply*

Preferred	Non-Preferred, Prior Authorization Required
Bydureon® Pens and Vials (exenatide ER)	Adlyxin® (lixisenatide)
Byetta® (exenatide)	Tanzeum® (albiglutide)
Victoza® (liraglutide)	Trulicity® (dulaglutide)

Growth Hormones

**Clinical prior authorization may apply*

Preferred	Non-Preferred, Prior Authorization Required
Genotropin® (somatropin)	Humatrope® (somatropin)
Genotropin® MiniQuick (somatropin)	Nutropin® AQ (somatropin)
Norditropin® FlexPro (somatropin)	Nutropin AQ NuSpin® (somatropin)
Omnitrope® (somatropin)	Saizen® (somatropin)
	Zomacton® (somatropin)

Hepatitis C Agents – Direct Acting

**Clinical prior authorization may apply*

Preferred	Non-Preferred, Prior Authorization Required
Zepatier® (elbasvir/grazoprevir)	Daklinza® (daclatasvir) Epclusa® (sofosbuvir/velpatasvir) Harvoni® (ledipasvir/sofosbuvir) Sovaldi® (sofosbuvir)/Olysio® (simprevir) in combination Technivie® (ombitasvir/paritaprev/ritonavir) Viekira Pak® (dasabuvir/ombitasvir/paritaprev/ritonavir) Viekira XR® (dasabuvir/ombitasvir/paritaprev/ritonavir)

Hepatitis C - Protease Inhibitors

**Clinical prior authorization may apply*

Preferred	Non-Preferred
Victrelis® (boceprevir)	

H₂ Antagonists

Preferred	Non-Preferred, Prior Authorization Required
Pepcid® (famotidine) Zantac® (ranitidine)	Axid® (nizatidine) Pepcid® (famotidine) oral suspension Tagamet® (cimetidine)

Homozygous Familial Hypercholesterolemia (HoFH) Agents

**Clinical prior authorization may apply*

Preferred	Non-Preferred, Prior Authorization Required
Kynamro® (mipomersen)	Juxtapid® (lomitapide mesylate)

Hypertriglyceridemia Agents

Preferred	Non-Preferred, Prior Authorization Required
Lovaza® (omega-3 acid ethyl esters)	Vascepa® (icosapent ethyl)



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ORAL/INJECTABLE/TOPICAL AGENTS (continued)

Immunomodulation Agents - Adult Rheumatoid Arthritis

**Clinical prior authorization may apply*

Preferred	Non-Preferred, Prior Authorization Required
Enbrel® (etanercept)	Actemra® (tocilizumab)
Humira® (adalimumab)	Cimzia® (certolizumab)
Xeljanz® (tofacitinib)	Kineret® (anakinra)
Xeljanz XR® (tofacitinib)	Orencia® (abatacept)
	Remicade® (infliximab)
	Rituxan® (rituximab)
	Simponi Aria® (golimumab)
	Simponi® (golimumab)

Immunomodulation Agents - Ankylosing Spondylitis

**Clinical prior authorization may apply*

Preferred	Non-Preferred, Prior Authorization Required
Enbrel® (etanercept)	Cosentyx® (secukinumab)
Humira® (adalimumab)	Remicade® (infliximab)
	Simponi® (golimumab)

Immunomodulation Agents - Crohn's Disease

**Clinical prior authorization may apply*

Preferred	Non-Preferred, Prior Authorization Required
Humira® (adalimumab)	Cimzia® (certolizumab)
	Entyvio® (vedolizumab)
	Remicade® (infliximab)
	Stelara® (ustekinumab)
	Tysabri® (natalizumab)

Immunomodulation Agents - Juvenile Idiopathic Arthritis

**Clinical prior authorization may apply*

Preferred	Non-Preferred, Prior Authorization Required
Enbrel® (etanercept)	Actemra® (tocilizumab)
Humira® (adalimumab)	Orencia® (abatacept)

Immunomodulation Agents - Plaque Psoriasis

**Clinical prior authorization may apply*

Preferred	Non-Preferred, Prior Authorization Required
Enbrel® (etanercept)	Amevive® (alefacept)
Humira® (adalimumab)	Cosentyx® (secukinumab)
Otezla® (apremilast)	Remicade® (infliximab)
	Siliq® (brodalumab)
	Stelara® (ustekinumab)
	Taltz® (ixekizumab)

PREFERRED DRUG LIST

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ORAL/INJECTABLE/TOPICAL AGENTS (continued)

Immunomodulation Agents - Psoriatic Arthritis

**Clinical prior authorization may apply*

Preferred	Non-Preferred, Prior Authorization Required
Enbrel® (etanercept)	Cosentyx® (secukinumab)
Humira® (adalimumab)	Remicade® (infliximab)
Otezla® (apremilast)	Simponi® (golimumab) Stelara® (ustekinumab)

Immunomodulation Agents - Ulcerative Colitis

**Clinical prior authorization may apply*

Preferred	Non-Preferred, Prior Authorization Required
Humira® (adalimumab)	Entyvio® (vedolizumab) Remicade® (infliximab) Simponi® (golimumab)

Inflammatory Bowel Disease Agents - Oral

Preferred	Non-Preferred, Prior Authorization Required
Azulfidine® (sulfasalazine)	Apriso® (mesalamine ER 24hr)
Delzicol® (mesalamine DR)	Asacol HD® (mesalamine DR)
Lialda® (mesalamine DR)	Colazal® (balsalazide disodium)
Pentasa® (mesalamine ER)	Dipentum® (olsalazine) Giazo® (balsalazide disodium) Uceris® (budesonide)

Insulin - Long-Acting

Preferred	Non-Preferred, Prior Authorization Required
Lantus® (insulin glargine)	Basaglar® (insulin glargine)
Lantus SoloStar® (insulin glargine)	Toujeo Solostar® (insulin glargine)
Levemir® Vial, FlexPen, FlexTouch (insulin detemir)	Tresiba FlexTouch® (insulin degludec)

Insulin- Short Acting and Intermediate Acting

Preferred	Non-Preferred, Prior Authorization Required
Humalog® multi-dose vial	Humalog® (excluding multi-dose vials)
Humalog® Mix multi-dose vial	Humalog® Mix (excluding multi-dose vials)
Humulin N® multi-dose vial	Humulin N® (excluding multi-dose vials)
Humulin R® multi-dose vial	Humulin R® (excluding multi-dose vials)
Humulin 70/30® multi-dose vial	Humulin 70/30® (excluding multi-dose vials)
Novolin N® multi-dose vial	Novolin N® (excluding multi-dose vials)
Novolin R® multi-dose vial	Novolin R® (excluding multi-dose vials)
Novolin 70/30® multi-dose vial	Novolin 70/30® (excluding multi-dose vials)
NovoLog® multi-dose vial, PenFill, & FlexPen	Velosulin BR® (excluding multi-dose vials)
NovoLog® Mix multi-dose vial, PenFill, & FlexPens	
Velosulin BR® multi-dose vial	



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ORAL/INJECTABLE/TOPICAL AGENTS (continued)

Lice Treatments

Preferred	Non-Preferred, Prior Authorization Required
Sklice® (ivermectin)	Natroba® (spinosad) Ovide® (malathion)

Meglitinides

Preferred	Non-Preferred, Prior Authorization Required
Prandin® (repaglinide)	Starlix® (nateglinide)

Methotrexate - Injectable

**Clinical prior authorization may apply*

Preferred	Non-Preferred, Prior Authorization Required
Rasuvo® (methotrexate)	Otrexup® (methotrexate)

Muscle Relaxants - Skeletal

Preferred	Non-Preferred, Prior Authorization Required
Flexeril® (cyclobenzaprine) Robaxin® (methocarbamol) Robaxin-750® (methocarbamol)	Amrix® (cyclobenzaprine ER) Fexmid® 7.5mg (cyclobenzaprine) Lorzone® (chlorzoxazone) Metaxall® (metaxalone) Norflex® (orphenadrine) Norgesic® (orphenadrine/aspirin/caffeine) Norgesic® Forte (orphenadrine/aspirin/caffeine) Parafon Forte DSC® (chlorzoxazone) Skelaxin® (metaxalone) Soma® (carisoprodol)

Muscle Relaxants - Spasticity

Preferred	Non-Preferred, Prior Authorization Required
Lioresal® (baclofen) Zanaflex® Tablets (tizanidine)	Dantrolene® (dantrolene) Zanaflex® Capsules (tizanidine)



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ORAL/INJECTABLE/TOPICAL AGENTS (continued)

Non-Steroidal Anti-Inflammatory Drugs - Oral

Clinical prior authorization may apply

Preferred	Non-Preferred, Prior Authorization Required
Advil® (ibuprofen)	Anaprox® (naproxen)
Aleve® (naproxen)	Anaprox DS® (naproxen)
Ansaid® (flurbiprofen)	Arthrotec® (diclofenac/misoprostol)
Cataflam® (diclofenac potassium)	Cambia® (diclofenac)
Clinoril® (sulindac)	Daypro® (oxaprozin)
EC-Naprosyn® (naproxen)	Dolobid® (diflunisal)
Indocin® (indomethacin)	Feldene® (piroxicam)
Mobic® (meloxicam)	Indocin® SR (indomethacin)
Motrin® (ibuprofen)	Lodine® (etodolac)
Motrin-IB® (ibuprofen)	Lodine® XL (etodolac)
Naprosyn® (naproxen)	Meclofenem® (meclofenamate)
Relafen® (nabumetone)	Nalfon® (fenoprofen)
Toradol® (ketorolac) (limited to a 5 day supply)	Naprelan® (naproxen)
Voltaren® (diclofenac sodium oral)	Naprelan® CR Dosepak (naproxen)
Voltaren® XR (diclofenac sodium oral)	Orudis® (ketoprofen)
	Orudis® KT (ketoprofen)
	Oruvail® (ketoprofen)
	Ponstel® (mefenamic acid)
	Tivorbex® (indomethacin)
	Tolectin 600® (tolmetin)
	Tolectin DS® (tolmetin)
	Vimovo® (naproxen/esomeprazole)
	Zipsor® (diclofenac)
	Zorvolex® (diclofenac)

Non-Steroidal Anti-Inflammatory Drugs - Topical

Preferred	Non-Preferred, Prior Authorization Required
Elector® Patch (diclofenac epolamine)	Pennsaid® (diclofenac)
Voltaren® Gel (diclofenac)	Sprix® Nasal Spray (ketorolac tromethamine)



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ORAL/INJECTABLE/TOPICAL AGENTS (continued)

Opioids - Long-Acting	
Preferred	Non-Preferred-Prior Authorization Required
Duragesic® (fentanyl)	Arymo ER® (morphine sulfate ER)
Embeda® (morphine/naltrexone)	Avinza® (morphine sulfate ER)
MS Contin® (morphine sulfate ER)	Belbuca® (buprenorphine)
OxyContin® (oxycodone SR)	Butrans® (buprenorphine)
Ultram ER® (tramadol ER)	ConZip® (tramadol)
	Exalgo® (hydromorphone HCl ER)
	Hysingla ER® (hydrocodone ER)
	Kadian® (morphine sulfate ER)
	Nucynta ER® (tapentadol)
	Opana ER® (oxymorphone)
	Ryzolt® (tramadol ER)
	Xartemis XR® (oxycodone/acetaminophen ER)
	Xtampza ER® (oxycodone ER)
	Zohydro ER® (hydrocodone bitartrate ER)

Pancreatic Enzyme Replacements	
Preferred	Non-Preferred, Prior Authorization Required
Creon® (pancrelipase)	Pertzye® (pancrelipase)
Pancrease® (pancrelipase)	Viokace® (pancrelipase)
Zenpep® (pancrelipase)	

PCSK-9 Inhibitors	
<i>*Clinical prior authorization may apply</i>	
Preferred	Non-Preferred, Prior Authorization Required
Repatha® (evolocumab)	Praluent® (alirocumab)

Phosphate Binder Agents	
Preferred	Non-Preferred, Prior Authorization Required
Eliphos® (calcium acetate)	Auryxia® (ferric citrate)
Phoslo® (calcium acetate)	Fosrenol® (lanthanum carbonate)
	Phoslyra® (calcium acetate oral solution)
	Renagel® (sevelamer HCl)
	Renvela® (sevelamer carbonate)
	Velphoro® (sucroferric oxyhydroxide)

Platelet Aggregation Inhibitors - Secondary Cardiac Prevention	
Preferred	Non-Preferred, Prior Authorization Required
Plavix® (clopidogrel)	Brilinta® (ticagrelor)
	Effient® (prasugrel)
	Zontivity® (vorapaxar)

Platelet Aggregation Inhibitors - Stroke	
Preferred	Non-Preferred, Prior Authorization Required
Plavix® (clopidogrel)	Aggrenox® (aspirin-dipyridamole ER)



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ORAL/INJECTABLE/TOPICAL AGENTS (continued)

Platelet Aggregation Inhibitors - Stroke

Preferred	Non-Preferred, Prior Authorization Required
Plavix® (clopidogrel)	Aggrenox® (aspirin-dipyridamole ER)

Proton Pump Inhibitors

Preferred	Non-Preferred, Prior Authorization Required
Dexilant® (dexlansoprazole)	AcipHex® (rabeprazole)
Prilosec® (omeprazole)	AcipHex® Sprinkles (rabeprazole)
Protonix® (pantoprazole)	Esomeprazole strontium® (esomeprazole strontium)
	Nexium® (esomeprazole)
	Nexium® Suspension (esomeprazole)
	Prevacid® (lansoprazole)
	Prevacid SoluTab® (lansoprazole)
	Prilosec® Packets (omeprazole)

Pulmonary Hypertension Agents

Preferred	Non-Preferred, Prior Authorization Required
Orenitram® (treprostинil)	Adcirca® (tadalafil)
Revatio® (sildenafil)	Adempas® (riociguat)
Tracleer® (bosentan)	Letairis® (ambrisentan)
	Opsumit® (macitentan)
	Uptravi® (selexipag)

SGLT2 (sodium-glucose co-transporter 2) Inhibitors

*Clinical prior authorization may apply

Preferred	Non-Preferred, Prior Authorization Required
Invokana® (canagliflozin)	Farxiga® (dapagliflozin) Jardiance® (empagliflozin)

Sleep Agents - Non-Scheduled

Preferred	Non-Preferred, Prior Authorization Required
Rozerem® (ramelteon)	Hetlioz® (tasimelteon) Silenor® (doxepin)

Sleep Agents – Scheduled - Non-Benzodiazepine

Preferred	Non-Preferred, Prior Authorization Required
Ambien® (zolpidem) Zolpidem generics	Ambien® CR (zolpidem CR) Belsomra® (suvorexant) Edluar® (zolpidem) Intermezzo® (zolpidem) Lunesta® (eszopiclone) Sonata® (zaleplon) Zolpimist® (zolpidem)



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ORAL/INJECTABLE/TOPICAL AGENTS (continued)

Statins

Preferred	Non-Preferred, Prior Authorization Required
Lipitor® (atorvastatin)	Altoprev® (lovastatin)
Mevacor® (lovastatin)	Crestor® (rosuvastatin)
Pravachol® (pravastatin)	Lescol® (fluvastatin)
Zocor® (simvastatin)	Lescol XL® (fluvastatin)
	Livalo® (pitavastatin)

Statin Combination (formerly Products for Hyperlipidemia)

Preferred	Non-Preferred
Caduet® (amlodipine/atorvastatin)	
Vytorin® (ezetimibe/simvastatin)	

Sulfonylureas – 2nd Generation

Preferred	Non-Preferred, Prior Authorization Required
Amaryl® (glimepiride)	Glucotrol XL® (glipizide XL)
DiaBeta® (glyburide)	Metaglip® (glipizide/metformin)
Glucotrol® (glipizide)	
Glucovance® (glyburide/metformin)	
Glynase PresTab® (micronized glyburide)	
Micronase® (glyburide)	

Thiazolidinediones

Preferred	Non-Preferred, Prior Authorization Required
Actos® (pioglitazone)	ACTOplus Met XR® (pioglitazone/metformin)
ACTOplus Met® (pioglitazone/metformin)	Avandamet® (rosiglitazone/metformin)
	Avandia® (rosiglitazone)
	Duetact® (pioglitazone/glimepiride)

Thrombopoietin Receptor Agonists (TPO)

*Clinical prior authorization may apply

Preferred	Non-Preferred, Prior Authorization Required
Nplate® (romiplostim)	Promacta® (eltrombopag)

Testosterone Agents- Topical

*Clinical prior authorization may apply

Preferred	Non-Preferred, Prior Authorization Required
Androderm® (testosterone)	Fortesta® (testosterone)
Androgel® (testosterone)	Testim® (testosterone)
Axiron® (testosterone)	Vogelxo® (testosterone)



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ORAL/INJECTABLE/TOPICAL AGENTS (continued)

Triptans

Preferred	Non-Preferred, Prior Authorization Required
Imitrex® (sumatriptan) tablets Maxalt® (rizatriptan) Maxalt-MILT® (rizatriptan) Relpax® (eletriptan)	Alsuma® (sumatriptan) Amerge® (naratriptan) Axert® (almotriptan) Frova® (frovatriptan) Imitrex® (sumatriptan) pens, vials, cartridges, nasal spray Onzetra Xsail® (sumatriptan) Sumavel DosePro® (sumatriptan) Zecuity® (sumatriptan) Zembrace Symtouch® (sumatriptan) Zomig® (zolmitriptan) Zomig-ZMT® (zolmitriptan)

Xanthine Oxidase Inhibitors

Preferred	Non-Preferred, Prior Authorization Required
Zyloprim® (allopurinol)	Uloric® (febuxostat)